PATIENT INFORMATION SHEET

TODAY'S DATE: _____/_____/_____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME: LAST: _____ FIRST:_____, M.I. _

DOB: ___/_____/_____ AGE: _____ SSN: _____ SEX: M / F

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

OCCUPATION:_____

OUT OF STATE ADDRESS: _____

E-MAIL ADDRESS: _____

MARITAL STATUS: Single _ Partnered _ Married _ Separated _ Divorced _ Widowed __

NEAREST RELATIVE/CONTACT PERSON: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

REFERRED TO OFFICE BY: _____

REASON FOR TODAY'S VISIT: _____

INSURANCE:

☐ WORKERS COMP ☐ AUTO_____ ☐ OTHER_____

DATE OF INJURY: _____

NAME OF ATTORNEY: _____PHONE #: _____

NAME OF EMPLOYER: _____

NATURE OF ACCIDENT: _____

AUTHORIZATION FOR RELEASE OF MEDICAL PHOTOGRAPHS:

Medical photographs may be taken before, during or after a surgical procedure or treatment. Consent is required to take such images. These images are used only for the education of other patients and physicians.

Date: _____

Patient Signature: _____

DATE:_____

MEDICAL HISTORY PAGE #1

Name: LAST:_____ FIRST:_____ MI_____

FAMILY DOCTOR:: _____ LAST PHYSICAL EXAM:_____

MEDICAL HSITORY: DO YOU NOW, OR HAVE YOU EVER, SUFFERED FROM THE FOLLOWING?

☐ DIABETES ☐ HEPATITIS ☐ EMPHYSEMA ☐ HIGH BLOOD PRESSURE ☐ HEART DISEASE

☐ EPILEPSY ☐ ASTHMA ☐ CANCER ☐ ANXIETY/DEPRESSION ☐ NONE

☐ BLEEDING TENDENCIES, PLEASE EXPLAIN _____

☐ OTHER PLEASE EXPLAIN_____

SURGICAL HISTORY: LIST ALL THE OPERATIONS YOU HAVE HAD:

TONSILLECTOMY / ADENOIDECTOMY ☐ Y ☐ N CHOLECYSTECTOMY (gallbladder) ☐ Y ☐ N

APPENDECTOMY ☐ Y ☐ N HYSTERECTOMY ☐ Y ☐ N C-SECTION ☐ Y ☐ N

OTHER PLEASE LIST: _____

LIST ANY ALLERGIES:

☐ Penicillin ☐ Other Drugs ☐ None

DESCRIBE REACTION: _____

NAME:_____

MEDICATIONS:

LIST ALL DRUGS OR MEDICATIONS THAT YOU ARE TAKING NOW OR HAVE TAKEN IN THE LST TWO WEEKS.

☐ ASPIRIN ☐ VITAMINS ☐ BIRTH CONTROL PILLS ☐ HERBS/SUPPLEMENTS

OTHERS Please list: _____

TOBACCO:

☐ NEVER SMOKED QUIT SMOKING WHEN? _____ PACKS PER DAY? _____ YEARS? _____

☐ CURRENT SMOKER PACKS PER DAY? _____ Years? _____

ALCHOHOL:

☐ NEVER DRANK ☐ VERY RARE SOCIAL DRINKING ☐ BEER / WINE

HOW MANY PER DAY?_____

"I understand that the above statements are true and accurate to the best of my knowledge.

" PATIENT SIGNATURE: _____**Date:** _____

Doctors Signature: _____**Date**: _____

DOCTORS NOTES:

MEDICAL HISTORY PAGE #2

PATIENT NAME: _____ DOB: _____ SS# _____

ZORAN POTPARIC MD
1116 E. Broward Blvd.
FORT LAUDERDALE, FL 33301

INFORMATIONAL:

Is the patient listed above a student at an accredited college or trade school? ☐ Yes ☐ No

If yes, please provide the following information

- Name of school:_____
- School address: _____
- Dates enrolled: _____ To:_____

If no, please provide the last date of attendance: _____

Does the patient have coverage under any other health benefit plan or insurance policy?
☐ Yes ☐ No

If yes, please provide the following information:

- Policyholder's name: _____
- Name of insurance company:_____
- Phone number:_____
- Effective date of coverage:_____
- Date when coverage may stop, if applicable:_____

PATIENT INFORMATION SHEET
Zoran Potparic, M.D. 1116 E. Broward Blvd, Ft. Lauderdale, FL 33301, For billing/collection please call: (954) 527-2677

FINANCIAL AGREEMENT

THE UNDERSIGNED agrees whether s/he signs as parent, spouse, guarantor, guardian, or patient, that in consideration of the services to be rendered to the patient, s/he herby individually Obligates himself/herself to pay the account. THE UNDERSIGNED UNDERSTANDS THOSE UNPAID ACCOUNTS WILL BE CONSIDERED IN DEFAULT AFTER ONE HUNDRED TWENTY DAYS (120), AFTER WHICH TIME INTERESTS WILL BE CHARGED AT THE RATE OF 1% PER MONTH ON THE UNPAID BALANCE. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. Dr. Potparic does NOT accept insurance. Patients are responsible for payment of all services rendered at the time of service. However, as a courtesy to patients, this office will assist patients by submitting bills to their insurance companies.

I HEREBY AUTHORIZE PAYMENT OF MEDICAL AND/OR PROFESSIONAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING PRIVATE INSURANCE AND ALL OTHER HEALTH PLANS TO ZORAN POTPARIC, M.D. THIS STATEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORGINAL.

I hereby authorize Zoran Potparic, M.D., to release my records to my insurance company, or company with any request from my insurance company to release my records to them.

I fully understand that any payment that I or my attorney receives made by my insurance company was solely intended for services rendered by Dr. Potparic. These checks must be sent to this office upon receipt. Failure to do so will immediately result in a 1% interest on the outstanding balance plus legal fees.

I understand that the information I am providing, including any phone numbers listed, may be used as a means of contacting me in the event that I do not pay for the services as agreed. I further understand that this permission extends to an outside collection agency or attorney if the account reaches 120 days or more past due.

I understand that in the event my account is referred for outside collections and /or to an attorney, that it may be reported to one or all of the National Credit Reporting Agencies.

PRINT PATIENT'S NAME_____ **DATE:** _____

PATIENT'S SIGNATURE: _____ **DATE:** _____

PARENT/SPOUSE/GUARANTOR:

NAME: _____**SS#**_____**DATE**:_____

SIGNATURE: _____ **DATE**: _____

FOR MEDICARE PATIENTS ONLY:
Medicare will only pay for services that it determines are "reasonable and necessary" under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary, Medicare will deny payment for that service. I understand that there is a $162.00 Medicare deductible every year that is solely my responsibility.

_____

Patient's or Authorized Signature **Date**

PATIENT INFORMATION SHEET

PATIENT CONSENT FORM

List names that you authorize Dr. Potparic and staff to speak to regarding your medical condition.

____

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The department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes for treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with your HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

PRINT NAME: ___________________________________ Signature: ______________________________________

DATE ____________

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COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients: The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule.” We

strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly Thank you for being one of our highly valued patients.